CHAPTER 19
Paranoid, Schizoid, and Schizotypal Personality Disorders

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Introduction

Our personalities are collections of behavioral, mental, and social characteristics that define us as individuals. Characteristics that are not temporally stable cannot establish replicable individual differences and therefore are not considered aspects of personality. For some of us, our personalities interfere with our abilities to form relationships, to control our impulses or emotions, to perceive ourselves and others accurately, and to enjoy life or to function at work. When such problems reach a sufficiently pathological extreme, personality is said to be disordered.

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV; American Psychiatric Association [APA], 1994), Personality Disorders (PDs) are characterized by inflexible, pervasive, stable, and enduring patterns of inner experience and behavior that deviate markedly from the expectations of the individual’s culture and lead to clinically significant distress or impairment in important areas of functioning. The maladaptive patterns of thought or behavior must be present at least by early adulthood, they must not be manifestations or consequences of other mental disorders, and they must not be caused by drug use or by medical conditions (see DSM-IV, p. 633, for general diagnostic criteria for a Personality Disorder).

In the DSM system of psychiatric diagnosis, PDs are grouped into three clusters (called A, B, and C) based on phenotypic similarity. Cluster A disorders include Paranoid, Schizoid, and Schizotypal PDs. The major commonality for these disorders is that affected individuals generally have very weak or nonexistent social attachments and odd or eccentric behavior. A second source of similarity for these disorders is that all three of them are found at higher rates in the families of schizophrenia patients, so that all three disorders may be alternative expressions of a similar genetic predisposition.

In this chapter, we focus on three Cluster A disorders. Seven major topics are presented: (1) a historical overview of both the schizophrenia spectrum concept and of the Cluster A personality disorders; (2) detailed descriptions of the disorders based on their modern (DSM-IV) diagnostic criteria; (3) epidemiology, including preva-
lence rates and intercorrelations (comorbidity rates)
of the disorders; (4) methods of assessment; (5) di-
mensional (continuous) alternatives to diagnostic
classification; (6) major theories of etiology; and
(7) leading treatments for Cluster A disorders.

Historical Overviews

History of the Schizophrenia
Spectrum of Disorders

It has been observed for many years that the
family members of psychotic patients often ex-
hibit symptoms similar to those of their psychotic
relatives, but of lesser severity. Nineteenth-century
American psychiatrist Isaac Ray was one of the
first to write on this topic. According to Ray
(1863), “the current philosophy … supposes that
the hereditary affection must appear in the off-
spring in precisely the same degree of intensity
which it had in the parent…. Such views are not
warranted by the present state of our knowledge
respecting the hereditary transmission of disease”
(p. 30). Ray believed that subtler aspects of mental
disorder deserved more attention than they were
receiving. He believed that mentally sound and
unsound elements could coexist in one individual
and he wrote of persons who “may get on very
well in their allotted part, and even achieve dis-
tinction, while the insane element is often crop-
ing out in the shape of extravagancies or irregu-
larities of thought or action, which, according to
the standpoint they are viewed from, are regarded
as gross eccentricity, or undisciplined powers, or
downright insanity” (Ray, 1863, p. 31).

Psychiatrists of the early part of the twentieth
century, such as Eugen Bleuler, Emil Kraepelin,
and Ernst Kretschmer, also described individuals
who were not frankly psychotic but had features of
psychotic illness. Bleuler and Kretschmer de-
scribed the family members of those with schizo-
phrenia by using terms such as schizoid, shut in, or
suspicious (Kendler, 1985). Bleuler coined the
term schizophrenia for what he believed was a
group of psychotic disorders, and he also coined
the term latent schizophrenia to describe cases
where features of schizophrenic illness were pre-
sent but in attenuated form. Gregory Zilboorg’s
(1941) ambulatory schizophrenia was merely
schizophrenia that was not striking enough to be
easily recognizable. Paul Hoch and colleagues
developed the diagnostic category of pseud-
oneurotic schizophrenia (Hoch & Cattell, 1959;
Hoch & Polatin, 1949; Hoch et al., 1962), whose
primary clinical symptoms were similar to the
symptoms of today’s Schizotypal PD. Rado (1953)
coined the term schizotypal, and Meehl (1962)
introduced the concept of schizotypy to define a
condition with an underlying inherited neural inte-
grative defect that could be manifested as anything
from mild distortions of thought and perception to
full-blown schizophrenia.

Even though these different writers seemed to
be describing very similar individuals, no single
term became clearly favored. During the middle of
the twentieth century, up to the 1970s, the adject-
vive schizoid (noun schizoidia) was often used
to describe schizophrenic-like individuals (e.g.,
Heston, 1970; Kallmann, 1938). This often confu-
ses today’s readers because the term schizotypal
has taken on the meaning once held by schizoid,
and the diagnostic criteria for Schizotypal PD cri-
teria are much more schizophrenia-like that those
for Schizoid PD.

In the late 1960s, Paul Wender, Seymour Kety,
and David Rosenthal used Danish adoption and
psychiatric records to undertake a series of studies
of the genetics of schizophrenia. Their research
methods were impeccable, and the published re-
sults of their “Danish adoption studies” were ex-
tremely influential—truly a watershed in the his-
tory of psychiatric research. Like the clinicians
and researchers who preceded them, these re-
searchers observed that biological relatives of
schizophrenic patients, even those who were not
schizophrenic themselves, sometimes exhibited
schizophrenic behaviors. The researchers inter-
preted the range of psychopathology in the family
members as evidence of a continuum or spectrum
of schizophrenic-like disorders with a similar ge-
etic basis:

We had recognized certain qualitative similarities in the fea-
tures that characterized the diagnoses of schizophrenia, uncer-
tain schizophrenia, and inadequate personality, which sug-
gested that these syndromes formed a continuum; this we
called the schizophrenia spectrum of disorders. If schizo-
phrenia were to some extent genetically transmitted, there
should be a higher prevalence of disorders in the schizophrenia
spectrum among the biological relatives of the index cases than
in those of their controls. (Kety, Rosenthal, Wender, & Schul-
singer, 1968, p. 353)

In later papers, the same authors used the term
“borderline schizophrenia” for individuals who